MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES (Rev., Jul 99)

DME - OVER $1,000.00

EST .LENGTH OF NEED (# OF MONTHS):_____ 1-99
(99=LIFETIME)

SECTION A

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH	PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER
MEDICAID I.D. NUMBER:	MEDICAID PROVIDER NUMBER:

RESIDENCE: (CIRCLE ONE) Home, Nursing Home, Hospital Rehab Unit, Group Home, Other:_____

DIAGNOSIS:

PROGNOSIS:

WHAT IS THE ANTICIPATED BENEFIT FOR PATIENT:

DATE OF LAST EVALUATION BY PHYSICIAN:	PHYSICIANS NAME:

SECTION B

1. Has the patient received a trial in the use of this item: Y / N

2. Does patient have the physical and mental ability to operate or use the item: Y / N

3. Can the patient or care-giver be responsible for the maintenance of this device: Y / N

4. Functional limitations of the patient: (Please circle)

   Contractures Paralysis Ambulation Impaired Comatose Muscle Weakness Respiratory Disease

   Disoriented Other (Please explain):

5. Narrative description of **ALL** items, accessories, sizes and options, etc., to included model numbers in this section: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

MONTANA
Department of Public Health & Human Services